LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV
MEETING MINUTES
June 12, 2014

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS ABSENT	DHSP STAFF
Michael Johnson, Esq., *Co-Chair*	Brad Land	Lynnea Garbutt	Douglas Frye, MD
Ricky Rosales, *Co-Chair*	Ted Liso/Douglas Lantis, MBA	Kimler Gutierrez *(pending)*	Juhua Wu, MA
Alvaro Ballesteros, MBA	Abad Lopez	AJ King, MPH	
Joseph Cadden, MD	Rob Lester, MPP	Patsy Lawson/Miguel Palacios	
Raquel Cataldo	Miguel Martinez, MSW, MPH	Victoria Ortega	
Kevin Donnelly	Marc McMillin	Mario Pérez, MPH	**COMMISSION STAFF/CONSULTANTS**
Michelle Enfield	José Munoz		
Lilia Espinoza, PhD	Angélica Palmeros, MSW		Dawn McClendon
Dahlia Ferlito, MPH *(pending)*	Gregory Rios		Jane Nachazel
Suzette Flynn	Juan Rivera		James Stewart
Aaron Fox, MPM	Jill Rotenberg		Craig Vincent-Jones, MHA
David Giugni, LCSW	Sabel Samone-Loreca/Susan Forrest		Nicole Werner
Terry Goddard, MA	Shoshanna Scholar		
Grissel Granados, MSW	Terry Smith, MPA		
Joseph Green/Erik Sanjurjo, MA	LaShonda Spencer, MD		
Sharon Holloway	Monique Tula		
David Kelly, MBA, JD	Terrell Winder		
Ayanna Kiburi, MPH (by phone)	Fariba Younai, DDS		
Lee Kochems, MA	Richard Zaldivar		
Mitchell Kushner, MPH, MD			
PUBLIC			
James Abuagye	Erin Adams	Robert Aguayo	Tania Aguilar
Vicki Ashley	Rene Bennett	Rose Bennett	Traci Bivens-Davis
Laura Bogart, PhD	Kuet Cabrerz-Miller	Danielle Campbell	Efron Chacan
Geneviéve Clavreul	Arcenio Cruz	Virginia Cubzein	Nettie DeAugustine
Oscar De La O	Niki Dhillon (by phone)	Joaquin Espinoza	Melissa Fisk
Christian Garcia	Daniela Garcia	Sherry Gonzalez	Bridget Gordon
Ted Goulet	Faith Idemundia	Miki Jackson	Mike Jones

PUBLIC *(cont.)*			
Uyen Kao	Sean Lawrence	Joseph Leahy	Eric Paul Leue
Karen Mark, MD (by phone)	Eduardo Martinez	Bryce McDavitt	Elizabeth Mendia
Steve Mercieca	Anthony Mills	Quiana Montazeri	Matt Mutchler, PhD
Kelsey Nogg	William Paja	Michael Pitkin	Nikki Rachad
Rotrease Regan	Yanira Reyes-Lopez	Ameerah Robate	Xochitl Santamaria
Walt Senterfitt	Kevin Stalter	Renee Stampolis	Damone Thomas
Enrique Topete	Brigitte Tweddell	Elaine Waldman	Chris Wilson
Jason Wise	Analilia Zaragoza		

1. **CALL TO ORDER**: Mr. Johnson opened the meeting at 9:25 am.
   A. **Roll Call** (**Present)**: Ballesteros, Caddan, Cataldo, Donnelly, Enfield, Espinoza, Ferlito, Flynn, Fox, Giugni, Goddard, Granados, Green, Johnson, Kelly, Kiburi, Kochems, Kushner, Land, Lester, Liso/Lantis, Lopez, Martinez, McMillin, Munoz, Rios, Rivera, Rotenberg, Samone-Loreca/Forrest, Scholar, Smith, Spencer, Tula, Winder, Younai, Zaldivar

2. **APPROVAL OF AGENDA**:
   MOTION 1: Adjust, as necessary, and approve the Agenda Order ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION 2: Approve minutes from the 2/13/2014 Commission on HIV meeting, as revised or presented ***(Passed by Consensus)***.
   MOTION 3: Approve minutes from the 3/13/2014 Commission on HIV meeting, as revised or presented ***(Passed by Consensus)***.
   MOTION 4: Approve minutes from the 4/10/2014 Commission on HIV meeting, as revised or presented ***(Passed by Consensus)***.
   MOTION 5: Approve minutes from the 5/8/2014 Commission on HIV meeting, as revised or presented ***(Passed by Consensus)***.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:**
   - Mr. Goulet announced Hollywood Remembers will host a resource fair and barbeque on 6/14/2014, 10:00 am to 2:00 pm. Testing will be available. Organizations could still sign up to participate by seeing him after the meeting.
   - Mr. Topete, Senior Programs Manager, announced the Wall Las Memorias will host a PrEP/PEP Community Forum in Boyle Heights with APAIT, Los Angeles LGBT Center, East LA Women's Center, APLA, Casa 101 and Central Pueblo. Light refreshments will be served and Spanish translation will be provided. Flyers were on the resource table.
   - Mr. Pitkin, a homeless PLWH, reported problems with the HUD and HOPWA Shelter+Care system, e.g., he signed up for several programs in February 2014. On following up, he found his data had not even been registered in some. He urged the Commission to address improving access to emergency, transition and permanent Section 8 housing.
   - Ms. Clavreul supported introduction of Zohydro ER, the first acetaminophen-free opiate. It is especially important for people like her with chronic pain because acetaminophen (Tylenol) damages the liver. Zohydro ER was approved by the Federal Drug Administration in December 2013. Deval Patrick, Governor, Massachusetts, tried to block release due to abuse concerns, but was overturned in court. Related articles were on the resource table or her blog, www.theworldasIseeit.com.

5. **COMMISSION COMMENT *(Non-Agendized or Follow-Up)*:**
   - Ms. Enfield. Program Coordinator, Red Circle Project, APLA Health and Wellness announced their 6/28/2014 Pow Wow. It honors the annual National Native HIV/AIDS Awareness Day. Booths remain available. Posters were on the resource table.
   - Mr. Land received a call from a former Commission member with hearing loss and early Alzheimer disease. A few weeks ago his in-home support services ended without notice leaving him unable to shop or address other activities of daily living. Ms. Cataldo helped reconnect him to services, but the situation exemplifies hazards of transitioning those with Medi-Medi to other systems. His case managers and nurses had not been paid since 4/1/2014. This issue will grow as PLWH age.
   - Mr. Fox noted the LA Gay and Lesbian Center has changed its name to the Los Angeles LGBT Center (The Center) and has a new logo. The name was changed to better reflect the population The Center serves.

6. **CONSENT CALENDER**:
   A. **Policy/Procedure #08.2107: Consent Calendar**: All remaining motions were pulled for discussion.

7. CO-CHAIRS' REPORT:

- Mr. Johnson clarified that the Commission does not engage in dialogue on subjects raised during public comment as they are not agendized so both time and preparation for a robust discussion are lacking.
- Commission members may refer a subject of interest raised in public comment to a committee for further review.

A. USCA/HIV & Aging Conference Attendance:

- The Commission would like to support as many Commission members as possible to attend USCA, San Diego and the HIV & Aging Conference, Atlanta. Any Commission member may receive conference support if s/he is attending to Commission business or representing it on a particular item. Otherwise, only unaffiliated consumers are eligible.
- The application and policy were in the packet. Applications should be submitted by 6/20/2014 for review.

B. "Sign-In/Out" Procedures:

- Mr. Johnson provided advance notice regarding a new procedure scheduled to start at the 7/10/2014 meeting. A memorandum and policy/procedure will follow shortly. Commission members will sign-in as usual at the start of the meeting, but will also sign-out with the time if they leave prior to final roll call.
- Consumer stipend policy requires attendance at a set number of meetings with 75% of a claimed meeting constituting attendance. Executive felt it inequitable to have two attendance standards so the procedure applies to all.
- The procedure will also offer the advantage of providing verification of quorum should a vote be questioned.

C. Summer Meeting Schedule:

- Mr. Johnson noted adjustments consequent to unification delayed work development, but now all four committees are working at full speed. The intensity of each committee's work usually raises and falls throughout the year so that not all are generating a full complement of work to bring forward to the Commission at the same time as they are now.
- The Executive Committee discussed options to accommodate the additional work. It was decided to add meetings to the schedule rather than hold full day meetings which present problems of fatigue and information overload.
- ➲ The summer schedule will be 7/10/2014; 7/24/2014; 8/7/2014; 8/14/2014. All will be from 9:00 am to 1:30 pm.
- ➲ The Annual Meeting will be held in November due to the other meeting changes. It is a single topic, all-day meeting.

1) Change of Date, September Meeting:

- Key Commission members and staff must attend a HOPWA conference as part of the Commission's HOPWA grant.

MOTION 6: Agreed to change the date of the monthly September Commission meeting to 9/18/2014 ***(Passed by Consensus)***.

D. Co-Chair Nominations:

- Mr. Stewart noted Co-Chairs normally serve two terms. One was designated as a one-year term with unification to initiate alternating terms. Mr. Rosales's term expires in December 2014. The policy provides for election in July with the new two-year term beginning in January to ensure the new Co-Chair has time to train for the position.
- Mr. Rosales and Ms. Palmeros were nominated. Ms. Palmeros declined the nomination.
- ➲ Co-Chair nominations were opened until elections at the 7/10/2014 Commission meeting. Mr. Rosales was nominated.

E. Member Changes: ➲ Fredy Ceja has resigned from the Commission. His Alternate, Mr. Munoz, will assume the full seat.

8. EXECUTIVE DIRECTOR'S REPORT:

A. Commission Meeting Evaluation Plan:

- Mr. Vincent-Jones reported evaluation of meetings will start in July. Feedback will be sought on a wide variety of topics, e.g., logistics, effectiveness, most interesting topics, best handled topics and participation in dialogue.
- A plan for the full year with multiple components is being developed by Dr. Espinoza, Mr. Lantis and Mr. Liso.
- ➲ It is expected that a baseline survey will be emailed to Commission members prior to the 7/10/2014 Commission meeting. Commission members are asked to complete and return the survey by the deadline requested on it.

9. PARLIAMENTARY TRAINING: There was no report.

10. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. California Planning Group (CPG):

- The first in-person meeting will be 6/25-26/2014 in Sacramento. Public comment information is on the CPG webpage at www.cdph.ca.gov/programs/aids/PagesOACPG.aspx. Contact Liz Hall, liz.hall@cdph.ca.gov, for other CPG information.
- Commission member Mr. Rivera is a CPG representative and can provide additional information.

B. OA Work/Information:

- Dr. Mark, Division Chief, and Ms. Dhillon, Chief, ADAP Branch joined Ms. Kiburi, Chief, HIV Care Branch for the report.
- Dr. Mark reported that the Governor's FY 2014-2015 Revised Budget, released 5/13/2014, maintains flat funding for the $6.65 million in General Fund support for the HIV/AIDS Surveillance program.
- Ms. Kiburi reported the HIV Care Program with its California Statewide Training and Education Program (CSTEP) contractor and other partners revised its benefits curriculum into two one-day trainings: "Lay of the Land: An Introduction to Health Care Benefits" and "Health Care Reform and HIV: New and Upcoming Health Care Programs of the Affordable Care Act." They will help HIV service providers support care for clients transitioning to other payers.
- Piloted in May, modules will be rolling out statewide in preparation for the October 2014 Covered California open enrollment. Ryan White providers are strongly encouraged to enroll those working directly with clients, e.g., case managers, benefits counselors, eligibility workers, outreach workers, patient navigators and health educators.
- Trainings are free. The calendar and training requests for groups of at least 12 can be accessed at www.CSTEP.org.
- Ms. Dhillon reported the ADAP 2014-2015 May Revision Estimate Package is available on the OA website. Senate and Assembly Budget Subcommittees approved the Estimate with two policy changes noted below as well as an ADAP November Estimate proposal authorizing the Franchise Tax Board to share state tax data with OA to verify applicant/client income eligibility for Ryan White programs. OA will work with the FTB to establish a contract to share the information. The goal is to ease the burden on clients and enrollment workers in providing income documentation.
- One of the May Estimate policy changes will add two new HCV drugs to the ADAP formulary, simeprevir and sofosbuvir. OA is working with the ADAP Medical Advisory Committee to prioritize those most in need and most likely to benefit, i.e., with advanced liver disease or other Hepatitis C manifestations affecting the rest of the body. Criteria were being completed for final Medical Advisory Committee review. Estimated FY 2014-2015 ADAP formulary cost is $26.1 million.
- Mr. McMillin suggested also prioritizing Hepatitis C patients who cannot tolerate interferon. Ms. Dhillon said these two medications are currently FDA approved for use with interferon. There is a small amount of data on use of the two drugs together without interferon in some patients so that will be allowed for those with certain types of Hepatitis C. A new medication is anticipated at the end of the year that is prescribed for use without interferon.
- The other policy change proposes OA develop the capacity to pay out-of-pocket medical expenses for eligible Health Insurance Premium Payment Program (OA-HIPP) clients. OA-HIPP can now pay insurance premiums and ADAP can pay medication co-pays and deductibles for ADAP formulary drugs, but other costs are uncovered. The change will support ADAP clients in enrolling in Covered California resulting in lowered ADAP costs and more comprehensive client care. OA will release an RFP for a Third Party Administrator (TPA) to pay costs with payments expected to start in January 2016.
- Ms. Dhillon responded to last month's question regarding Anthem Blue Cross not accepting OA-HIPP payments. All plans have accepted payments. There was a problem earlier in the year with Blue Shield Covered California which was accepting, but not applying, payments due to problems with a TPA. That has been resolved.
- Mr. Vincent-Jones asked if patients who paid their Blue Shield premiums to avert coverage loss would be repaid. Ms. Dhillon replied OA-HIPP cannot reimburse them, but if they were also enrolled in OA-HIPP then Blue Shield would have received two payments so patients could request reimbursement from Blue Shield. Mr. Rivera added that has worked.
- Another question pertained to OA-HIPP client frustration with delayed return calls, service and enrollment. The volume of enrollment calls was higher than expected so processing applications and paying premiums were prioritized.
- Staff is working to catch up on calls to enrollment workers and clients. OA-HIPP is also re-organizing the Branch for more staff to handle the next enrollment's work load. The goal is to return calls within 48 hours. Dr. Mark stressed OA is aware and doing its best to resolve the issue. There was a surge of calls especially near the end of enrollment.
- Mr. Rivera left three messages for his enrollment worker and the supervisor since last month. Only Richard Martin, Section Director, ever responds. Kevin, representing a small provider, added they helped approximately 180 people apply for OA-HIPP with Blue Shield, but payments for 40 people did not come through. Most abandoned their policies and were out of care. He and Mr. Rivera urged addressing this year's issues before next year's open enrollment.
- Ms. Dhillon said OA-HIPP is working with its pharmacy benefits manager to develop an electronic OA-HIPP application to be part of the ADAP application for the next open enrollment period. It will allow enrollment workers to submit both at the same time and track progress online to facilitate better communication. She did not backlog data, but felt the number was much reduced. Staff is now working to communicate payment information to enrollment workers.
- Mr. Johnson asked about delays in OA-HIPP payment checks to continue COBRA coverage. Ms. Dhillon replied it takes approximately three weeks to process an application. Once approved, information is sent to the accounting office which provides a hard copy check. OA-HIPP is reviewing how to improve the process for the next open enrollment.

- Mr. Fox complemented OA for identifying and working to solve issues. HRSA should acknowledge providers have encouraged people to sign up for Covered California since application numbers have been high.

➲ Staff will email information to Ms. Dhillon on the 40 people whose OA-HIPP Blue Shield payments were not made.

11. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT:

A. Administrative Agency: Mr. Pérez was in Atlanta leading the DHSP delegation at the National STD Prevention Conference.

B. HIV/STD Services: There was no report.

C. Research/Surveillance:

1) HIV Epidemiology Profile:

- Dr. Frye presented a PowerPoint on the Annual Update of the Epidemiologic Profile of HIV in Los Angeles County.
- He reviewed County HIV surveillance which began with AIDS case surveillance in 1982. California initiated coded non-AIDS HIV surveillance in 2002 and named reporting with Viral Loads (VLs) in 2006.
- CD4 reporting was added in 2008 and the Enhanced HIV/AIDS Reporting System (eHARS) launched. eHARS allows serial reporting on the same person which enhanced surveillance data use for clinical and public health purposes.
- In 2013, the California Emergency Public Health Regulation approved a new HIV testing algorithm for laboratories with two new kinds of tests which detect HIV earlier and one of which discriminates between HIV1 and HIV2.
- The National HIV Surveillance System also expanded to include all states in 2013.
- The 2012 estimate for adults and children worldwide living with HIV has increased to 35.3 million. The rate for adults and adolescents in the United States living with HIV was approximately 342 persons per 100,000 in 2011 or 879,335. The County rate was 532 per 100,000 in 2013 or 45,148 which is comparable to rates for Florida, California, Texas, New York and Georgia, but less than the District of Columbia at 2,700 per 100,000. It is slightly higher than the rate for California and comprises 40% of California cases and approximately 5% of national cases.
- Among US Metropolitan Statistical Areas in 2011, Los Angeles (which includes Orange County) was third after Miami (which includes West Palm Beach and Fort Lauderdale) and New York in new infections.
- However, the County is the largest local jurisdiction in the US at 10 million. Its rate of HIV cases in 2011 at 18 per 100,000 is lower than other jurisdictions except for King County, WA. Similarly, while the County reported 64,979 STD and HIV cases in 2012, its STD rate is often lower than other jurisdictions, e.g., its P&S syphilis rate is 8. 2012 STD and HIV cases were: 74.4%, Chlamydia; 17.5%, gonorrhea; 4.8%, syphilis; and 2.9%, HIV/AIDS.
- The CDC has lowered its estimate for persons living with HIV who are unaware of their status to 15.8%. The County had 50,550 reported HIV/AIDS cases in 2013 and uses the 15.8% to estimate 9.500 unaware.
- 2012 Annual Report data reflects 1,911 new HIV infections reported with highest percentages in the 20-29 age group followed by 30-39 at 28% and 40-49 at 21%. US HIV diagnoses in 2008-2011 reflects 79% male and 21% female compared to County diagnoses for 2008-2012 which reflects 89% make, 9% female and 2% transgender.
- By race/ethnicity, 47% of US reported 2011 cases are among Black/African-American (Black/AA) followed by White at 28% and Hispanic/Latino at 21% with Asians and others in the 1-2% range. Dr. Frye noted the particular disparity between the 12% US population of Black/AA and that population's 47% of diagnoses.
- 2012 County diagnoses by race/ethnicity are: Latino, 49%; White, 23%; Black, 21%; Asian/Pacific Islanders (A/PI), 5%; and American Indian/Alaska Natives (AI/AN), 1%. Most are similar to County populations, but the Black population is 9% with diagnoses at 21% while A/PI and White diagnoses are proportionately lower.
- The average County rate of persons diagnosed with HIV in 2012 is 19 per 100,000. The Latino rate is similar at 20 with the White rate slightly lower at 15 and the A/PI rate significantly lower at 7. Those rates contrast with the much higher Black rate of 48. The AI/AN rate of 51 marks the first time it exceeded the Black rate.
- The MSM transmission category in the US for 2008-2011 has risen to 60% while the heterosexual category has slightly declined to 30%. The County 2008-2013 MSM transmission category has risen from 80% to 85% while the heterosexual category slightly declined to 8.6%. IDU and MSM/IDU together were 3.8%.
- PLWH with HIV and Stage 3 HIV (AIDS) has consistently risen from 1991 to 2013 reflecting improved care. 75% are over 40 with a median age of 48. It is notable that about half of new AI/AN diagnoses were among those under 40.
- The proportion of male to female PLWH in 2013 varies per race/ethnicity. Of Black PLWH, 20% are female which is a significantly higher proportion than for White, 5%; A/PI, 10%; AI/AN, 11%; or Latino, 12%.
- County transmission categories differ markedly by gender. In 2013, key male categories were: 88%, MSM; 7%, MSM/IDU; 3%, IDU. Key female categories were: 75%, heterosexual contact, 21%, IDU; 3%, mother with HIV. Dr. Frye noted many female IDUs often have sexual risk factors, e.g., exchange sex and loss of power in relationships.

- Comparing data for all PLWH in the County as of 12/31/2013 with diagnoses in 2012 reflects several trends. In particular, Latinos increased from 41% to 49% and A/PI from 3% to 5% while Whites declined from 33% to 23%. Among transmission categories, MSM increased from 77% to 85% while all other categories declined.
- Geographic distribution of the 5,968 new diagnoses in 2010-2012 follows the familiar pattern for PLWH with high levels in the Metro, West Hollywood and South Los Angeles area with a secondary focus in Long Beach.
- HIV Epidemiology completed a comparison study of US versus 2009/2010 County HIV care continuum indicators. Diagnosed (82%) and Linked to care (66% and 65%) data were consistent, but the County exceeded US percentages for retained in care, 46% versus 37%; prescribed ART, 41% versus 33%; and virally suppressed, 34% versus 25%.
- County HIV surveillance and Medical Monitoring Project (MMP) data for 2011 remained 82% for diagnosed. Linked to care was viewed as linked within 3 months, 66%; 6 months, 69%; and 12 months, 71%. Similarly, retained in care was reflected as PLWH with a minimum of two Viral Loads (VLs) at least three months apart, 47%; and PLWH with at least one VL within the last 12 months, 56%. Prescribed ART remained 41%. The viral suppression rate of 45% is very good and may reflect under-reporting of retention in care. 19,228 PLWH were in the 2010 RW system of care with 14,753 in medical care. Of those, 90% are on ART, 87% retained in care and 75% have an undetectable VL.
- Among MSM, Black MSM reported living with HIV in 2011 had the lowest rate of linkage to care within three months of diagnosis, 78% versus 84% overall and up to 87% for White MSM, and the lowest rate of suppressed VL, 70% versus 82% overall and up to 88% for AI/AN MSM. Black MSM alone was below 80% for both indicators.
- There were 547 transgender women and 26 men reported in eHARS at year-end 2013, but that is notably lower than DHSP's estimate of 1,088 transgender women and 40 men living with HIV in the County in 2012.
- 83% of the 29 transgender persons reported to eHARS as diagnosed in 2011 were linked to care within three months, but only 49% of those living with HIV and 68% who had at least one VL in 2011 were virally suppressed.
- 60% of transgender women living with HIV are over 40, but that is slightly lower than overall County PLWH at 75%.
- 2013 data, however, reflects notable race/ethnicity differences among transgender women versus all PLWH in the County. In particular, 52% of transgender women are Latino versus 41% of all PLWH and 31% are black versus 20% of all PLWH, but just 9% are White versus 33% of all PLWH.
- HIV Incidence Surveillance (HIS) is a national CDC effort to estimate the rate and number of new HIV infections per year versus those diagnosed in a year who may have been infected earlier. HIS combines surveillance data with laboratory-based technology and a person's testing and treatment history to develop estimates.
- The County estimate range per year for 2010 and 2011 is 1,500 to 2,500 with a mean of 2,035 new HIV infections.
- The County has participated in the National HIV Behavioral Surveillance (NHBS) study since 2005. NHBS alternates annual studies of 550 MSM, IDUs and high-risk heterosexuals. MSM data is from sites where MSM gather. IDU uses respondent-driven sampling. Heterosexual data is gathered from sites based on poverty and heterosexual HIV prevalence. Additional respondent-driven data is collected from sites chosen from those geographic areas.
- NHBS is not population-based so cannot be generalized to the public, but can reflect trends, e.g., Black MSM HIV prevalence remained highest per race/ethnicity, but declined from 2004 to 2011. Prevalence for White MSM, second in 2004, and Latino MSM, third in 2004, remained in the mid-range but changed places by 2008. A/PI prevalence remains low. MSM PLWH unaware of their status appears to be declining. The next MSM study starting in July will clarify that both HIV+ and HIV- participants will receive stipends to reduce potential self-reported bias.
- IDU prevalence trends are unreliable as data is only available from 2009 and 2012, but Black and White rates are much higher than for Latinos. The Black heterosexual rate is low, but others were zero or could not be measured.
- Approximately half of MSM and MSMW with primary and secondary syphilis are co-infected with HIV per laboratory evidence, but self-report of approximately 60% is likely more accurate.
- HIV is the strongest known risk factor for progression from latent to active TB. PLWH are more likely to be infected with TB if exposed and those with untreated latent TB have a 10% chance per year to develop active TB.
- Since 1981, 2.2% of the 82,650 persons reported with HIV in the County were co-infected with active TB. In 2013, 1.2% of the 576 PLWH were co-infected, but in the last 10 years overall less than 1% of HIV cases were co-infected.
- Regarding Hepatitis C (HCV), the CDC reports HIV-HCV co-infection leads to more rapid progression to liver disease. 25% of US PLWH are co-infected with HCV and 50-90% of PLWH who are IDUs are co-infected. Comparatively, 2004 County data indicates 3-5% of PLWH co-infected with HCV and 46-65% of PLWH who are IDUs co-infected.
- Since 1997, mortality has only declined slightly in the County. A gap also remains between deaths reported from Stage 3 HIV Disease (AIDS) and the somewhat fewer PLWH deaths reported due to another cause although some of those may have purposely been misreported. The median age of death increased from 37 in 1987 to 50 per preliminary 2013 data. With a median age of 48, it is likely however that PLWH are living longer than 50.

- HIV data presented includes the Long Beach and Pasadena Local Health Jurisdictions, but STD data excludes them.
- Average income level is compared, usually by census tract, to race/ethnicity and the HIV rate. HIV rates generally decline as income rises, but some high income Black rates are higher than for lower income Whites and Latinos.
- Regarding transmission from mother to child, Dr. Frye reported one County case of perinatal transmission of HIV in 2013, but overall transmission has been zero for some time. Congenital syphilis is syphilis in a newborn contracted from a mother with untreated syphilis. The number of such County cases is small, but outcomes are very poor.
- Mr. Giugni asked how transgender persons are asked to self-identify. Dr. Frye replied the County has surveyed the population since 2002 and the CDC has included it on its case report form since 2006. The four options are: male, female, male to female or female to male. There is a separate variable in HARS and eHARS.
- DHSP believes the population is significantly under-reported. In some cases, transgender women or men do not self-identify as such and, especially in early epidemic years, some clerical staff resisted reporting them. DHSP used sero-prevalence and population estimates to estimate transgender persons living with HIV. Much data is electronically transmitted so does not provide information such as sex identified at birth.
- The Annual Report provides transgender data in some tables, but not others either if numbers were too small for reliable data or where CDC data did not include it. DHSP is advocating for CDC to consistently include the data.
- He noted AI/NA and transgender persons, especially transgender women, are small County population, but have high HIV prevalence rates. Estimates are needed due to the small populations. An AI misclassification study a few years ago found only half had been documented as AI in surveillance data. That has since improved.
- Multi-race data remains an issue. The CDC classifies a person as multi-race if one piece of data identifies the person as Latino and another as AI even though the person may be one or the other. DHSP counts a person as AI if there is any evidence of AI. Another match with the Indian Health Service and other databases is planned.

13. **STANDING COMMITTEE REPORTS**:

A. Operations Committee:

1) Member Renewal/Nomination Plan 2014:

- Mr. Green reported the application process has been extended. Applications will be available 6/16/2014 and emailed to Commission members. Applications will be accepted for 30 days.
- Interviews will be held in July for all competitive seats. Commission members who are not re-applying are requested to complete an exit interview at the Commission offices.

B. Planning, Priorities and Allocations (PP&A) Committee:

1) FY 2015 Priority- and Allocation-Setting (P-and-A) Framework and Process:

- The purpose of the P-and-A framework and process is to ensure timely deliberation of all pertinent information.
- In April, PP&A agreed P-and-A would integrate prevention and care funding and allocations into a comprehensive process planning for the full continuum of HIV services. PP&A selected paradigms and operating values in May.
- Goals for June are: review the local epidemiological profile to chart demographic and disease-related trends and evaluate the overall epidemic; review the new integrated service definitions list; and review 2011 LACHNA data while redesigning the next LACHNA to reflect prevention and care. PP&A will also consider how to better integrate provider input. Previous efforts such as a forum in each SPA have not resulted in helpful data.
- Service categories will be ranked from most to least needed by consumers in July. Ranking is solely based on need regardless of funding. Preliminary allocation strategies needed for RW and CDC applications will also be developed.
- DHSP will provide a Service Utilization Report in August along with an assessment of Fee-For-Service services.
- PP&A is initiating a patient composites allocation methodology to fully integrate prevention and care. Composites for HIV- and HIV+ patients will be defined in July and August and populated with data through November.
- In September, PP&A will assess disease burden change, e.g., via geo-spatial analysis of syndemic infection clusters, and compare local outcomes to other scales, e.g., the National HIV/AIDS Strategy, national/local treatment cascades and Comprehensive HIV Plan goals. Comparison data will inform the annual combined Commission/DHSP report to the Board on progress in ending the epidemic as well as setting benchmarks to measure future progress.
- PP&A reviews financial expenditure data monthly, but the October focus will be an in-depth review of all financial information including resource inventory development, identification of alternate funding sources and the impact of ACA implementation. The system capacity model will be populated with data and gaps/barriers analyzed.
- In November, PP&A will set resource allocations for funding from RW Part A and MAI, RW Part B from OA, CDC prevention and HOPWA alignment. PP&A also provides DHSP with Net County Cost recommendations.

- Targeted allocations will be defined by percentage in December after taking into consideration additional factors, e.g., vulnerable populations, disparities/co-morbidities, interventions/effectiveness and geography/housing.
- Contingency funding scenarios will be developed in February 2015 prior to receipt of awards. That provides the opportunity to plan calmly how to address awards that may vary significantly from projected funding.
- In February 2015, PP&A will develop directives to DHSP, the Commission and other stakeholder institutions expressing expectations, recommendations or guidance for work such as studies to achieve objectives for the next year. PP&A also reviews the entire P-and-A process to ensure the highest quality, most effective process in future.
- This recommended timeline reflects a heavy work load so may need to be adjusted to accommodate other work.
- PowerPoint slides will be available on the Commission's website at www.hivcommission-la.info.

MOTION 7: Approve the proposed FY 2015 Priority- and Allocation-Setting (P-and-A) framework and process, as presented ***(Passed by Consensus)***.

2) FY 2015 Paradigms/Operating Values:

- Selecting paradigms and operating values facilitates decision-making by establishing core principles in advance in an open and transparent manner. They provide a common PP&A perspective to evaluate and prioritize information as well as to help in making more contentious or difficult decisions such as in times of funding reductions.
- Paradigms represent different world views and ethical perspectives for making decisions and the lenses participants use in decision-making. They may be grouped into justice paradigms, valuing everyone equally with even and fair treatment, and disparity paradigms, urging special care and compassion for the disenfranchised.
- Justice paradigms are: equality, equity, fairness, altruism, coercion, compassion, chance, utilitarianism, merit, rights and duties, retributive justice, distributive justice, market and fidelity.
- Disparity paradigms are: absolute inclusion, nuanced inclusiveness and risk equalization.
- PP&A evaluates differing views represented by paradigms, strengths and weaknesses, how they apply to P-and-A decision-making and how various paradigms reflect participants' views.
- Operating values are participant codes of conduct representing core principles of behavior for the process itself. They are: efficiency, survival, quality, fidelity, beneficence, non-maleficence, advocacy, access, barriers and representation. This year PP&A added effectiveness for consideration at its 5/27/2014 meeting.
- All PP&A meeting participants ranked three paradigm and three operating value choices with three points for their first choice, two for their second and one for their third. The highest ranking three of each group were selected.
- PowerPoint slides will be available on the Commission's website at www.hivcommission-la.info.

MOTION 8: Approve the selection of "Utilitarianism," "Compassion," and "Nuanced Inclusiveness," as stated paradigms, and "Quality," "Access>' and "Effectiveness" as stated Operating Values, for the FY 2015 P-and-A process, as presented ***(Passed by Consensus)***.

3) FY 2015 P-and-A Pledge Form: This item was postponed.

C. Public Policy Committee:

1) FY 2014-2015 State Budget Update:

- Mr. Fox reported the Assembly and Senate passed their budgets. They are now being reconciled in Conference Committee. The Legislature's deadline for its final budget is 6/15/2014.
- In 2009, Governor Schwarzenegger vetoed over $80 million in General Fund dollars for HIV. The state has not funded HIV programs since. This year, due to an improved economy, the California HIV Alliance asked for re-investment in HIV with a focus on programs that are evidence-based and exploit scientific advances since 2009.
- The Assembly was more interested in re-investment and allocated slightly more than $13 million for HIV programs including a community and provider PEP/PrEP education campaign, linkage to care demonstration projects, a couple of million dollars each for syringe access and to modernize ADAP eligibility by addressing household size.
- The Senate allocated approximately $5 million and has not seemed amenable to increasing the amount so the final budget is unlikely to offer more. Governor Brown has publicly opposed new General Fund spending so funds may not survive his veto. Advocates should urge the Governor's Office to retain any HIV funding in the Legislature's final budget. Regardless of the outcome, discussion of new funding is a good first step in a multi-year effort.

2) Troy and Alana Pack Patient Safety Act – Qualified November Ballot Measure:

- Mr. Fox noted several Commission members and members of the public asked Public Policy to review this.
- Currently, the Medical Injury Compensation Reform Act (MICRA), passed in 1975 and upheld in 2008, provides unlimited economic damages for medical costs, lost wages and lifetime earning potential; as well as unlimited punitive damages for malicious or willful misconduct. It caps damages for pain and suffering at $250,000.

- Public Policy would likely have supported this initiative if it only raised the MICRA cap to address inflation. However, it also requires random mandatory drug and alcohol testing for physicians and requires tracking controlled substance use via the CURES database prior to prescribing medication.
- The Pack children, Troy and Alana, were killed by a hit-and-run driver heavily medicated with prescription drugs.
- While sympathetic, Public Policy does not feel sufficient data has been presented to indicate the scope and nature of issues with physicians practicing while impaired or prescribing medications recklessly and does not feel the purported remedies would be effective. The initiative also appears to conflict with California's medical marijuana policy since THC is included under physician drug testing. Public Policy therefore recommends opposition.
- Mr. Vincent-Jones said there is no set County process to address initiatives. Positions are rare and usually due to a Supervisor's advocacy. If the motion passes, the next step would be to advocate for a formal County position. Many County leaders already appear opposed including Dr. Mitchell Katz, Director, Department of Health Services (DHS) though DHS itself has not yet taken a position. The Commission would initiate advocacy with DHS.
- County opposition is likely due to the potential financial impact. Costs have been estimated from a minimum of tens of millions of dollars annually to the Legislative Analyst's estimate of hundreds of millions annually.
- Ms. Clavreul opposes the initiative. It started to address MICRA's pain and suffering cap which was valid, but now includes other issues. The testing section is inequitable as it only applies to physicians and not, e.g., anesthetists who are nurses. Tracking medications with CURES is problematic, e.g., it cannot communicate with 23 other states.
- Mr. Liso stressed his overriding concern was the impact on prescription of pain medication for those with chronic conditions. As a PLWH, he has taken pain medications for 15 years. They allow him to function, but recently his prescriptions have undergone extreme scrutiny. The problem with medications is not valid prescriptions, but pills in circulation illegally, e.g., the recent investigation of "loose pills" at CVS which only resulted in a fine.

MOTION 9: Oppose the Troy and Alana Pack Patient Safety Act of 2014, an initiative that has qualified as a measure on the statewide November ballot, and forward recommendation to the LA County Board of Supervisors, Chief Executive Office (CEO) and its Intergovernmental Relations (IGR) unit, County Counsel, the Departments of Health Services, Public Health and Mental Health, and other County departments and entities, as appropriate, in order to encourage formal County opposition to the measure ***(Passed by Consensus)***.

D. Standards and Best Practices (SBP) Committee: This item was postponed.

14. HIV COMMUNITY COLLOQUIA SERIES: PRELIMINARY FINDINGS FROM PROJECT MEDNET:

A Study of the Social Networks of African American Men and Women Living with HIV:

- Ms. Kao, UCLA Center for HIV Identification, Prevention and Treatment Services (CHIPTS) introduced Drs. Bogart and Mutchler. The presentation and updated PowerPoint will be available on the CHIPTS website, www.chipts.ucla.edu.
- Dr. Bogart is Associate Professor, Pediatrics, Harvard Medical School and Research Director, General Pediatrics, Boston Children's Hospital. She specializes in the application of social psychological theory to HIV-related health disparities.
- Dr. Mutchler is Professor, Sociology, and Director, Urban Research Center, CSU Dominguez Hills and Community Based Researcher, APLA. He has researched social/cultural contexts of HIV prevention and treatment for 25 years.
- The key finding is that social networks may affect PLWH HIV treatment behaviors such as use of and adherence to ART. Networks may be helpful if others in them are on ART and if interconnections are strong, but may be harmful if they are stigmatizing, include more drug partners or if those important to a person in the network spread misinformation about HIV.
- The effect of social networks on perceptions of behavioral and health norms has been studied in areas such as sexual risk, substance use, and health issues like diabetes. The study was meant to address the scarcity of such HIV research.
- Social network characteristics that may affect treatment behaviors include types of people such as family, friends, social service agency staff, other PLWH, sex/drug partners; their health behaviors; and beliefs which may, e.g., be stigmatizing.
- The overarching research question was how social network characteristics are associated with HIV treatment behaviors across the HIV treatment cascade regarding engagement/retention in care, ART use and ART adherence.
- Data was collected from 242 African-American adult PLWH in Los Angeles over one year by self-report, medication electronic use verification and medical records review (still being analyzed). Participants represented those engaged in care and not engaged, adherent and not adherent, and virally suppressed and not virally suppressed. They were recruited through agencies and local media. Surveys were done via audio computer-assisted interviewing.
- Participant mean age was 46.6 with 74%, male; 21%, female; transgender, 5%; with 62% MSM and 38% heterosexual. Income was <$10,000/year for 68% with 91% not working, 28% not in stable housing and 23% not high school graduates.

- Mr. Lawrence, APLA, reported participants named 20 alters (people in their social networks) they had seen, phoned, mailed or emailed in the past year. They provided each alter's gender, race/ethnicity, age, sexual orientation, relationship with participant, HIV status, ART use; monthly frequency of contact; and annual frequency of alter-to-alter contact.
- On average, participants took 64% of their doses, but just 43% took at least 85% of their doses.
- Alters were: 42%, female; 65%, heterosexual; 19%, HIV+. Of PLWH, 96% were on ART. Alters were 83% Black with most friends, 59%, or family, 32%, but 9% were drug-using and 5% sex partners. Alters could be in multiple categories. Stigmatizing comments were made by 33% of alters. Many alters, 52%, were not connected to any other network alters.
- Participants were less likely to be on ART if they were lower income and their social networks included a lower percentage of HIV+ alters on ART. Participants were also less likely to be on ART if their social networks had a higher percentage of drug-partner alters with higher drug-partner drug usage, rather than participant's usage, associated with lower ART use.
- Retention in care, defined as greater than one visit in the past six months, was less likely for participants in social networks with a greater percentage of drug-partner alters and a lower percentage of HIV+ alters on ART.
- Relation of ART use and retention in care to the same network factors suggests social norm influence on health behaviors.
- Participants reporting that at least one alter expressed stigmatizing beliefs were less likely to be ART adherent, but effects were moderated by changes in social support with an increased proportion of isolated alters over time detrimental and increased interaction frequency with alters over time protective. Causality cannot be inferred, but results suggest network factors may impact disparities in HIV treatment behaviors. Data has not yet been analyzed regarding discrimination from people participants said they knew in religious organizations, but network data does include alters with religious ties.
- Dr. Mutchler said the research team hoped for input on how to best use findings. One possibility is to use community-level interventions to promote social network support for healthy behaviors and to reduce stigma. Another possibility is substance use interventions that encourage interaction with new alters to improve treatment behaviors.
- A related study with many of the same team members, Project Rise, is currently hosted by APLA. Ms. Rachad, Facilitator, Project Rise, a culturally tailored African-American adherence intervention, reported stigma is a key issue in interviews.
- Mr. Stalter, Thrive Tribe, said the group was formed a few years ago to bring HIV+ men together for social activities, e.g., going to the beach or a house party. New members are interviewed about ART use and adherence. Approximately 20% have never been in care and others are in care sporadically primarily due to drug use. HIV- men are also welcome.
- Approximately 10% of members are African-American to date, but outreach continues. Thrive Tribe has grown from 300 to 1,000 members in the last 12 months with 75-80% referred from other members' social networks. Most referrals are from sexual networks with some from friends or partners. He noted stigma impacts men's ability to have open, honest HIV status conversations. Approximately half of new members thought they were in monogamous relationships, but were not.
- Mr. Leue, an HIV- member of Thrive Tribe, found it welcoming and nonjudgmental. He suggested the Commission host a presentation. He also recommended the national organization, Mr. Friendly, which explores how HIV is addressed within the leather community, i.e., what words drive people away or draw them in. It can be contacted via #stigmafree.
- Ms. Enfield suggested adding AI/NA and A/PI data to the treatment cascade.
- Mr. Donnelly felt the electronic pill bottle caps to measure uptake would be an adherence issue. He prepares a week's worth of medications at a time in daily pill containers. Mr. Lawrence said participants reported no issues with the caps.
- Regarding cultural beliefs about HIV, Dr. Mutchler reported participants were asked about their beliefs. Data is still being analyzed, but this week some results were found to be significant for health outcomes, e.g., conspiracy and toxicity.

15. HOPWA REPORT: This item was postponed.

16. CAUCUS REPORTS: The Consumer Caucus met after the Commission. Transgender and Latino Caucus reports were postponed.

17. CITY/HEALTH DISTRICT REPORTS: This item was postponed.

18. AIDS EDUCATION/TRAINING CENTERS (AETC): This item was postponed.

19. **SPA/DISTRICT REPORTS**: This item was postponed.

20. TASK FORCE REPORTS: This item was postponed.

21. **COMMISSION COMMENT:** Ms. Samone-Loreca announced Trans Pride, 6/13-14/2014, LA LGBT Center. The event is free.

22. ANNOUNCEMENTS: Ms. Jackson noted comments at organization meetings that agencies had difficulty meeting testing targets because AIDS Healthcare Foundation was paying $50 per test at Out of the Closet. She stressed no payments are made.

23. ADJOURNMENT: The meeting adjourned at 1:45 pm in memory of June Chu, DHS staff analyst, who worked tirelessly to improve cost effectiveness and quality, saving the County millions of dollars and increasing access to specialty care.

A. Roll Call (Present): Ballesteros, Caddan, Donnelly, Enfield, Ferlito, Fox, Goddard, Granados, Green, Holloway, Johnson, Kelly, Kochems, Land, Liso/Lantis, Lopez, Martinez, McMillin, Munoz, Palmeros, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Smith, Spencer, Winder, Younai

MOTION AND VOTING SUMMARY		
MOTION 1: Adjust, as necessary, and approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the 2/13/2014 Commission on HIV meeting, as revised or presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve minutes from the 3/13/2014 Commission on HIV meeting, as revised or presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Approve minutes from the 4/10/2014 Commission on HIV meeting, as revised or presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 5: Approve minutes from the 5/8/2014 Commission on HIV meeting, as revised or presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 6: Agreed to change the date of the monthly September Commission meeting to 9/18/2014.	***Passed by Consensus***	**MOTION PASSED**
MOTION 7: Approve the proposed FY 2015 Priority- and Allocation-Setting (P-and-A) framework and process, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 8: Approve the selection of "Utilitarianism," "Compassion," and "Nuanced Inclusiveness," as stated paradigms, and "Quality," "Access>' and "Effectiveness" as stated Operating Values, for the FY 2015 P-and-A process, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 9: Oppose the Troy and Alana Pack Patient Safety Act of 2014, an initiative that has qualified as a measure on the statewide November ballot, and forward recommendation to the LA County Board of Supervisors, Chief Executive Office (CEO) and its Intergovernmental Relations (IGR) unit, County Counsel, the Department of Health Services, Public Health and Mental Health, and other County departments and entities, as appropriate, in order to encourage formal County opposition to the measure.	***Passed by Consensus***	**MOTION PASSED**